



# MOBILE 3D Advantage, LLC

Your Southern California Premier Dental Imaging Company

Please Call For An Appointment:  
(949) 282-0083

Fax: (949) 382-1442  
Email: mobile3dadvantage@yahoo.com  
Website: www.mobile3dadvantage.com

Date of Scan: \_\_\_\_\_

**\*\*ATTENTION PATIENTS\*\***

- PAYMENT IS REQUIRED AT TIME OF APPOINTMENT UNLESS DOCTOR TAKES RESPONSIBILITY ON THIS FORM**
- 3D Advantage does **NOT** accept assignment of insurance. We will provide a receipt for services rendered.
- 24-HOUR CANCELLATION IS REQUIRED OR A FEE WILL BE APPLIED.**

## PLEASE PRINT CLEARLY IN ALL FIELDS

Patient Name: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_  
 Referring Doctor: \_\_\_\_\_  
 Office Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_

### FORMAT OPTIONS(MUST CHECK)

Images Printed (1mm Slices) –   
 Burn to CD –  Pdf  Jpeg  DICOM  
 Interactive Viewer- Measurements aren't needed   
 Email-  Pdf  Jpeg  DICOM  
 Interactive Viewer- Measurements aren't needed   
 Email Address: \_\_\_\_\_

Payment Responsibility:  Doctor  Patient(Fee\$\_\_\_\_\_)

## Dental Cone Beam CT Procedure(Must Check)

### Implant Survey

Maxillary Arch  
 Tooth # \_\_\_\_\_  
 Entire Arch  
 Mandibular Arch  
 Tooth # \_\_\_\_\_  
 Entire Arch

**Teeth Will Be Separated Unless Marked**  
 Teeth In Occlusion  
 Patient Wears Stent  
 Dual Scan Protocol (Included In Fee)

### Impacted Tooth Survey

Tooth #: \_\_\_\_\_

### TMJ Survey

Closed Only(Transaxial Included)  
 Open/Closed  
 At Rest

### Pathology Survey

Tooth # \_\_\_\_\_

Panorex  
 Orthodontic Scan (Ceph+Pano)  
 Radiologist Report  
**Additional Fee \$125**  
 Intraoral scan  
**Additional Fee - \$125**

RIGHT								LEFT							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

PHYSICIAN ID: \_\_\_\_\_ AUTHORIZED SIGNATURE: \_\_\_\_\_

3rd Party Company(Lab) Email: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

## Please Print Clearly

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Male/Female  
 City \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ **Female Patients – Are you Pregnant? Yes/No**  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Office Only

Patient Only

Tech Only

Van Number: \_\_\_\_\_ Procedure: \_\_\_\_\_ Next Appt W/Dr.: \_\_\_\_\_ Technician: \_\_\_\_\_  
 Scan Charge: \$ \_\_\_\_\_ Additional Charges: \$ \_\_\_\_\_ Total: \$ \_\_\_\_\_  
 Delivered: Prints: \_\_\_\_\_ CD: \_\_\_\_\_ Email: \_\_\_\_\_  
 Doctor or Patient Doctor or Patient